Ohio
Department of Medicaid

Pharmacy Provider Manual
Billing Procedure Guide

Administered by:
Goold Health Systems-
A Change Healthcare Company

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Revised:

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Section 1: Introduction

Goold Health Systems (GHS), a Change Healthcare company, is the claims processor for the Ohio Department of Medicaid (ODM) fee-for-service pharmacy benefit management program. GHS uses a computerized point-of-sale (POS) system, utilizing NCPDP D.0 telecommunications standards for claim transactions.

The system allows participating pharmacies real-time access to consumer eligibility, drug coverage, pricing and payment information, and prospective drug utilization review (ProDUR) across all network pharmacies. Pharmacy providers must be enrolled through ODM and have an active status for any dates of service submitted.

This manual is intended to provide pharmacy claims submission guidelines to the users of the GHS on-line system. Additionally, it contains instructions for claims submissions via paper media using the Universal Claim Form (UCF). While there are a variety of different pharmacy operating systems, the information contained in this manual addresses only the response messages related to the interaction with the GHS on-line system.

When pharmacy providers require assistance with processing a claim for an Ohio Medicaid consumer in the fee-for-service pharmacy program, they may contact the **GHS Technical Call Center,** which is **available 24 hours per day, seven days per week,** at: **1-877-518-1545.**

1.1 Help Desk Telephone Numbers

Department	Contact Information
GHS Technical Helpdesk and Technical Prior Authorizations	1-877-518-1545 Available 24 hours a day, seven days a week
GHS Clinical Prior Authorizations	1-877-518-1546 Fax: 1-800-396-4111 Monday – Friday from 8am – 8pm (ET)
ODM Provider Enrollment/ Revalidation Hotline	1-800-922-3042 Monday – Friday from 8am – 4:30pm (ET)
ODM Provider Assistance **Remittance Advice (835)**	1-800-686-1516 Monday – Friday from 8am – 4:30pm (ET) http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderAssistance.aspx
Ohio Medicaid Consumer Hotline	1-800-324-8680 TTY 1-800-292-3572 Monday – Friday from 7am – 8pm (ET); Saturday from 8am – 5pm (ET) Voice mail is available at other times with calls returned the next business day http://ohiomh.com/

ODM Web Site Addresses

http://medicaid.ohio.gov The Ohio Medicaid Program

http://pharmacy.medicaid.ohio.gov The Ohio Medicaid Drug Program and a searchable database of covered drugs

https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx Ohio Medicaid Information Technology System (MITS) web portal

1.2 Mailing Addresses

Provider Paper Claims Billing Address

Goold Health Systems, a Change Healthcare Company
P.O. Box 1030
Columbus, Ohio 43216-1030

Prior Authorization Appeals (consumers only)

Ohio Department of Medicaid
Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

1.3 Service Support

On-line Certification

Providers must submit claims using NCPDP version D.0 of the telecommunications standard.

On-line System Not Available

If for any reason the on-line system is not available, providers should submit claims when the on-line capability resumes. In order to facilitate this process, the provider's software should have the capability to submit backdated claims.

Technical Problem Resolution

Technical problems that may arise unrelated to the standard claims processing rejections, may require technical expertise from the pharmacy provider software vendor, the pharmacy's internal technical support team, or network support staff. The **GHS Technical Call Center** (**1-877-518-1545)** is available for assistance related to technical issues involving the GHS POS system and questions related to the payer sheet.

Section 2: Program Setup

2.1 Claim Format

Electronic

GHS will accept electronic claims submitted via NCPDP version D.0 telecommunications standards. Payer sheets for claims transmission are available at:

> The Ohio Medicaid Drug Program: http://pharmacy.medicaid.ohio.gov

> Goold Health Systems: http://www.ghsinc.com/payer-sheets

Paper (Manual)

Manual claims follow the same business rules and edits as online claims. These paper claims use the NCPDP Universal Claim Form (UCF) and are processed in a timely manner (within 14 calendar days of receipt). Claims with invalid or incomplete information from the submitting provider will be returned within one business day of receipt along with a cover letter explaining the reason why the claim(s) is being rejected. Paper Claims may be submitted to:

> **Goold Health Systems, a Change Healthcare Company**
> **P.O. Box 1030**
> **Columbus, Ohio 43216-1030**

Information about the UCF is available from NCPDP at: http://www.ncpdp.org/products.aspx.

2.2 Media Options

ODM does not accept Batch Claim submissions. Mandatory POS submission is required for all providers except:
- Clinics
- Other providers with prior approval from ODM

2.3 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally GHS will also accept re-bill claims (Transaction Code B3).

- **Claims Adjudication (Transaction Code B1)**

  This transaction captures and processes the claim and returns a paid or denied claim response to the pharmacy.

- **Claims Reversal (Transaction Code B2)**

  This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system.

  <u>**NOTE:**</u> The following fields must match on the original paid claim and on the void request for a

successful claim reversal:

- Service Provider ID

- Prescription number

- Date of service (date filled)

- NDC

- **Claims Re-bill (Transaction Code B3)**

  Use this transaction to adjust and resubmit a claim that has previously been processed and received a **Paid** status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction.

- **Eligibility Verification (Transaction Code E1)**

  Use this transaction to transmit patient billing number and receive a real time response verifying eligibility.

2.4 Required Data Elements

The GHS system has program-specific requirements for data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields.

ODM claims will not be processed without all the required data elements. Required fields may or may not be used in the adjudication process. The complete ODM Payer Specifications, including NCPDP field number references, are in the payer sheet, posted online at: http://pharmacy.medicaid.ohio.gov. Fields "not required for this program" at this time may be required at a future date.

<u>NOTE:</u> The following list provides important identification numbers for this program:
- ANSI BIN # **015863**
- Processor Control # **OHPOP**
- Group # **Not needed**
- Provider ID # **National Provider Identifier (NPI) Number**
- Cardholder ID # **Ohio Medicaid ID Number**
- Prescriber ID # **NPI**
- Product Code **National Drug Code (NDC), Universal Product Code (UPC), National Health Related Items Code (HRI)**

2.5 Timely Filing Limits

In accordance with OAC 5160-9-06, ODM accepts claims for up to 365 days from the date of service. The GHS Help Desk has the ability to do a manual override for timely filing limits in such cases where retro-active eligibility or delayed TPL have occurred. Claims that exceed the prescribed timely filing limit will deny with the NCPDP Reject Code: 81 - Claim Too Old. A summary of the timely filing limits is provided below.

Claim Type	Timely Filing Limit
Original Claims (B1 transaction)	Within 365 days of the date of service.
Reversals (B2 transaction)	Within 575 days of the date of original claim adjudication date.
Re-bills (B3transaction)	Within 365 days of the date of service or beyond 365 days if the re-bill is within 120 days original claim adjudication date.
Denied Claims	Denied claims may be re-submitted beyond 365 days if the re-submission is within 90 days of the original claim denial.

2.6 Unique Claim Criteria

The POS system will use three NCPDP data elements to identify a unique claim:

Date of Service: NCPDP field #4Ø1-D1

Service Provider ID: NCPDP field #2Ø1-B1

Prescription Reference Number: NCPDP field #4Ø2-D2

If the incoming submitted claim (B1/B3) matches the three NCPDP elements to a non-voided claim then, NCPDP Reject code: 83 - Duplicate Paid/Captured Claim will display. An incoming reversal (B2) or resubmit (B3) must also match on the same 3-part key or it will reject with NCPDP Reject code: 87 - No claim on file to reverse.

Submitted Fill Number (NCPDP field #4Ø3-D3)

The submitted fill number for the same Service Provider ID and Prescription Reference Number do not need to be sequential, but it should be higher than the previous fill number. If criteria are not met, the provider will receive the NCPDP Reject code: 17 - M/I Fill Number – Fill number must be greater than previous fill number.

The subsequent fill number for the submitted claim must match the prior claim on drug, strength and formulation. If the provider changes the drug, dose or formulation, the rejection message sent is NCPDP Reject code: M4 - PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT - Different Medication from Previous Fill Contact Help Desk.

Section 3: Program Policies

3.1 Requirement for Tamper-Resistant Prescription Forms [OAC 5160-9-06]

Tamper-Resistant Prescription Forms

All written prescriptions billed to Medicaid must be on tamper-resistant forms. This includes written prescriptions when ODM is not the primary payer and pays only a portion of the claim. Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing are exempt from this requirement. To be considered tamper resistant a prescription form must contain all three of the following tamper-resistant characteristics.

Required Characteristic	Examples include but not limited to:
1. One or more features designed to prevent unauthorized copying of a completed or blank prescription form	• Text that appears when photocopied or scanned (e.g., "void" or "illegal") • Microprint borders that cannot be copied
2. One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	• Erasure or use of solvents will discolor background • Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74,etc.)
3. One or more features designed to prevent the use of counterfeit prescription forms	• Thermochromic ink • High security watermark • Sequentially numbered • Duplicate or triplicate blanks

The tamper-resistant requirement does NOT apply in the following situations:
- Payments for prescriptions made by an ODM-contracting managed care plan.
- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone.
- Orders for medications administered in a provider setting and billed by the administering provider.
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have the opportunity to handle the written order.

Emergency Fill of Non-Tamper-Resistant Prescription

If a written non-tamper resistant prescription is presented, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber **within 72 hours of dispensing**. The pharmacist should use professional judgment to define an emergency situation. A compliant tamper-resistant prescription may be obtained by the following methods:
- A compliant written prescription, fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription.
- The pharmacy may verify the prescription by telephone documenting (on the prescription) the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

Retroactive Eligibility

- If a consumer is determined to be retroactively eligible for Medicaid coverage, and the pharmacy has filled a prescription for a date of service that falls into the retroactive eligibility period, the pharmacy must verify that the original prescription was tamper resistant.
- If the original prescription was not tamper resistant, the pharmacy may follow the procedures listed above to obtain a replacement tamper-resistant prescription or verify the prescription by phone, prior to billing the claim to ODM.

3.2 Dispensing Limits [OAC 5160-9-03]

Days Supply

The maximum days supply per claim is 34 days for most drugs. Certain exceptions may apply to specific drug classes or medications managed in the formulary. Medications that are typically prescribed for long-term maintenance therapy are allowed up to 102-day supply. The following is a list of the drug classes that allow a higher days supply to be dispensed:

Drug Class	Examples
ENDOCRINE	
CONTRACEPTIVES	Norethindrone/ethinyl estradiol, Levonorgestrel/ethinyl estradiol
CORTICOSTEROIDS	Budesonide, Dexamethasone, Prednisone
ESTROGENS/PROGESTINS	Conjugated Estrogens, Estradiol, Medroxyprogesterone
HYPOGLYCEMICS, ORAL	Glyburide, Metformin, Pioglitazone, Acarbose
INSULINS	Insulin glargine, Insulin NPH, Insulin Regular, Insulin Lispro
OSTEOPOROSIS AGENTS, ORAL	Alendronate, Calcitrol, Raloxifene
THYROID AGENTS	Levothyroxine, L-thyroxine
CARDIOVASCULAR	
ANGINA/HTN/HF AGENTS	Amlodipine, Atenolol, Benazepril/HCTZ, Carvedilol, Digoxin, Diltiazem, Isosorbide MN, Lisinopril, Losartan, Metoprolol, Valsartan/HCTZ
ANTIARRHYTHMICS	Propafenone, Quinidine, Sotalol
ANTICOAGULANTS, ORAL	Warfarin
ANTIPLATELET INHIBITORS	Clopidogrel, Dipyridamole, Prasugrel
DIURETICS	Furosemide, HCTZ, Spironolactone
LIPOTROPICS	Atorvastatin, Fenofibrate, Niacin ER
COUGH, COLD & ALLERGY	
RX AND OTC	Cetirizine, Diphenhydramine, Fluticasone, Loratadine, Loratadine/PSE
RESPIRATORY	
ANTIASTHMATIC/COPD AGENTS	Albuterol, Formoterol, Ipratropium, Montelukast, Salmeterol/fluticasone, Tiotropium
CENTRAL NERVOUS SYSTEM	
ANTIDEPRESSANTS	Amitriptyline, Duloxetine, Sertraline
ANTICONVULSANTS	Carbamazepine, Gabapentin, Topiramate
ANTIPARKINSON AGENTS	Benztropine, Pramipexole, Ropinirole
MISCELLANEOUS	
GENITOURINARY AGENTS	Darifenacin, Oxybutynin, Tamsulosin
PANCREATIC ENZYMES	Pancrealipase
URICOSURIC AGENTS	Allopurinol, Probenecid
VITAMINS & MINERALS	Calcium+D, Daily MVI, Ferrous sulfate, Magnesium, Potassium, Prenatal

Quantity Limitations: Dose/Duration

Maximum prescription quantities represent the largest number of units per drug that may be dispensed at any one time for a single prescription or the largest number of units per drug per day (or other time period) of therapy. Proposed quantity limitations are reviewed and approved by the ODM DUR Board.

Claims submitted that exceed either the days supply limit or maximum quantity limit shall be denied. Denials may be overridden by GHS Technical Call Center in cases where medical necessity has been determined.

In an effort to combat the risk of acetaminophen toxicity and opioid overuse, ODM has established a maximum quantity on opioid-acetaminophen combination products. The maximum allowed dose is 3,000mg per day of acetaminophen. Additional quantity limits are available online at: The Ohio Medicaid Drug Program: http://pharmacy.medicaid.ohio.gov.

Date Rx Written to Date of Service (DOS) Edits

In accordance with Ohio pharmacy regulations [OAC 4729-5-21], all prescriptions must be filled within 180 days from the date written. The GHS point-of-sale system will display a 'soft' message back to the pharmacy if the Date Written (NCPDP field #414-DE) is not within 183 days of the first fill.

For all subsequent fills, the Date of Service (NCPDP field #4Ø1-D1) must be within 366 days from the Date Written. [OAC4729-5-30] The POS system will produce a hard rejection when the limit is exceeded with NCPDP Reject code: 28 - M/I DATE PRESCRIPTION WRITTEN – Fill date exceeds Ohio Dept of Medicaid 366 days.

Refills

All refills must be dispensed in accordance with State and Federal requirements. As noted in the above section, refills may not exceed one year from the Date Written (NCPDP field #414-DE). The refill rate for the ODM pharmacy program is seventy-five percent. The calculation is based upon the most recent script fill date and quantity. Refills requested before seventy-five percent of the days supply has been utilized will be denied, other than in cases where the dosage of a drug has been increased and has a new prescription number. The pharmacy will receive the NCPDP Reject code: 79 – Refill Too Soon Next Fill <Date>.

Pharmacy providers will have the ability to override the NCPDP Reject code: 79 – Refill too Soon for the same drug and same strength when a dosage change occurs. The pharmacy will need to submit a Submission Clarification Code = 05 (NCPDP field#42Ø-DK). The dosage (quantity/days supply) on the submitted claim MUST be greater than the previous claim it is rejecting against. **This override will NOT be available for controlled substances.**

NOTE: Claims will not pay for an early refill if the original quantity is not used up. The POS logic looks at the last fill and calculates if member has used up previous fill based on the dosage increase.

Denials may be overridden by the GHS Technical call Center staff for the following documented reasons:
- Previous supply was lost, stolen, or destroyed. ODM may limit the number of instances denials may be overridden in cases of suspected fraud or abuse, and may request additional documentation before an override is authorized.
- Pharmacist entered previous wrong day supply.
- Vacation or travel.
- Multiple supplies of the same medication are needed, for example in a workshop setting.
- Hospital or police kept the medication.

Controlled Substances
- CII prescription cannot be refilled; a new prescription is required for each fill. Long-term Care (LTC) can do partial fills of a CII drug as long as they follow the guidelines for partial fills.
- CIII and CIV controlled drugs may be refilled up to 5 refills (plus one original) or 6 months, whichever comes first. GHS will provide a 'soft' message back to the pharmacy if this limit is exceeded.
- CV controlled drugs, like non-controlled drugs, may be refilled up to one year.

3.3 Provider Dispensing Fees [OAC 5160-9-05]

ODM has a flat rate standard dispensing fee of $1.80 with exceptions. Durable medical equipment (DME) and specific clinic providers do not receive a dispensing fee. Vaccines and recipients in a LTCF have a different dispensing fee structure. IV and TPN products in compounds get a maximum dispensing fee based upon days supply.

Category	Dispense Fee
Standard prescription	$1.80 per claim
Compound (standard) prescription	$6.00 per prescription
Total Parenteral Nutrition (TPN)	$15.00 per day, capped at $150.00
Infusion Compounds, Non-TPN	$10 per day, capped at $70.00
Durable Medical Equipment (DME)	$0.00
Influenza vaccine in LTCF	$0.50 per claim
Influenza vaccine administered at the pharmacy	$10.00 administration fee

Long-Term Care Facility (LTCF)

Consumers, identified as living in a long-term care facility, including nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID), have the following dispensing fee structure:
- **Non-controlled drugs:** one dispensing fee per drug/strength/formulation, per recipient, per pharmacy, per rolling 25 days.
- **Controlled drugs (CII – CV):** two dispensing fees per drug/strength/formulation, per recipient, per pharmacy, per rolling 25 days.

A pharmacy can submit a '5' in the Prior Authorization Type Code (NCPDP field# 461-EU) that will override the LTCF dispensing fee limit only (all other edits still apply). If a pharmacy is submitting a 72-hour override and a dispensing fee override, they can submit '8' in the Prior

Authorization Type Code field and a '35' in the Prior Authorization Number Submitted field (NCPDP field #462-EV) to override both. Acceptable criteria for a provider to utilize the override feature include cases where:

- The physician has prescribed a second round of medication within the 25-day period.
- The physician has increased the dose.
- The medication did not last for the intended days supply.
- The drug has been compromised by accident (e.g., contaminated or destroyed).
- The drug being dispensing is a controlled substance (limited to two dispensing fees per month).

Compounds

Standard compound dispensing fee is $6.00 with the exception of TPN and Infusion drugs. If multiple dispensing fee types exist in a single claim, the highest allowed dispensing fee is paid. IV (Infusion) dispense fees are paid as $10.00 multiplied by the number of days supply, up to a maximum of $70.00 per claim. TPN dispense fees are paid as $15.00 multiplied by the days supply, up to a maximum of $150.00 per claim.

Only one TPN compound claim per day is allowed per Medicaid consumer. If more than one TPN compound claim is submitted for a recipient on the same date of service, the NCPDP Reject code: 76 – 'Plan Limitations Exceeded – Plan does not allow multiple TPN claims per day' will be displayed.

3.4 Generic Substitution Policy

While ODM encourages generic drug use, drugs included in the ODM Drug File are considered reimbursable, regardless of their brand or generic designation. When generic substitution is being performed, pharmacists should practice in accordance with ORC 4729.38. This includes only substituting when the prescriber has not indicated that the brand drug should be "dispense as written" (DAW).

3.5 Drug Coverage [OAC 5160-9-03]

Overview

Drugs covered by the Ohio Medicaid pharmacy program are limited to those that are manufactured or labeled by companies participating in the federal Medicaid rebate program. Drugs must also be dispensed by duly enrolled providers and are covered or prior authorized prescription, over-the-counter, or compounded medications.

Medications Not Covered
The following list describes medications that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for the treatment of obesity.
- Drugs for the treatment of infertility.
- Drugs for the treatment of erectile dysfunction.
- DESI drugs or drugs that may have been determined to be identical, similar, or related.
- Drugs that are covered or may be covered by Medicare Part D, when prescribed for a consumer who is eligible for Medicare, unless Medicaid coverage is for a dual eligible as designated in the subsequent paragraphs.

- Drugs being used for indications not approved by the Food and Drug Administration unless there is compelling clinical evidence to support the experimental use.

Durable Medical Equipment (DME)/Disposable Medical Supplies (DMS)

Limited equipment and supplies (listed below) are covered through the pharmacy program when billed by a pharmacy provider. These supplies should be billed using the NDC or UPC on the package through the pharmacy POS claim system. Claims billed to Medicare Part B or a Medicare Advantage plan as the primary payer will continue to be paid when billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). Other equipment and supplies not listed below, including enteral nutrition products, should be billed as DME.

Contact the ODM Provider Network Management at 1-800-686-1516 for more information. Claims submitted to GHS for services not listed in the table below will be denied.

HCPCS Code*	Description
A4245	Alcohol wipes or swabs
E2100	Blood glucose monitor with integrated voice synthesizer
A4253	Blood glucose test or reagent strips for home blood glucose monitor
A4252	Blood ketone test or reagent strip
A4268	Contraceptive supply, condom, female
A4267	Contraceptive supply, condom, male
E0607	Home blood glucose monitor complete
S5560	Insulin delivery device, reusable pen; 1.5ml size
S5561	Insulin delivery device, reusable pen; 3ml size
A4259	Lancets
A4215	Needles only, sterile, any size, including pen needles
A4256	Normal low and high calibration solutions or chips
A4614	Peak Expiratory Flow Rate Meter, hand held
A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler
A4258	Spring-powered device for lancet
A4206	Syringe with needle, sterile less than or equal to 1 cc
A4250	Urine test or reagent strips or tablets

*The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. These supplies will be paid by the NDC number instead of the HCPCS code.

Medicare Part B

Consumers indicated as having Medicare Part B on the Date of Service are not covered for Part B drugs (see examples below) under Medicaid and these claims will reject with some exceptions. Cost sharing for drugs covered by Medicare Part B must not be billed to the Medicaid consumer. Medicaid will pay the claim through the standard Medicare crossover process. If payment has not been received from Medicaid within 90 days, follow the billing instructions found at: http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535543-provider-billing-instructions.

Category	Description
Anti-emetic Oral Drugs	When used as a part of a chemotherapeutic regimen.
Antigens (some)	If prepared by a physician and given by a properly instructed individual under appropriate supervision.
Blood-clotting Factors	Patients with hemophilia that give themselves their own injections.
Chemotherapeutic Oral Drugs	Some oral cancer drugs are covered if the same drug (or prodrug) is available in injectable form.
DME infused Drugs	Medicare covers drugs infused through equipment such as albuterol nebulizer solution and IV medications.
End-Stage Renal Disease (ESRD) Oral Drugs	Some oral ESRD drugs are covered if available in the injectable form and covered by Part B.
Erythropoiesis-stimulating Agents	Patients with ESRD or using the drug to treat anemia related to other conditions.
Injectable and Infused Drugs	Medicare covers most injectable and infused drugs given by a licensed medical provider.
IV Immune Globulin (IVIG)	Patients with primary immune deficiency disease when IVIG is administered in the home.
Nutrition, Parenteral/Enteral	Certain nutrients may be paid for patients who can't absorb nutrition through their intestinal tracts or take food by mouth.
Osteoporosis Injectable Drugs	Women with the home health benefit and a bone fracture certified as related to post-menopausal osteoporosis.
Self-administered Drugs	Medicare may cover some self-administered drugs provided in hospital outpatient settings.
Transplant Drugs (Immunosuppressants)	If Medicare paid for the organ transplant, transplant drug therapy may be covered.
Vaccinations	Influenza, Pneumococcal, Hep B and other shots directly related to the treatment of an injury or illness.

https://www.medicare.gov/coverage/prescription-drugs-outpatient.html

Medicare Part D Dual Eligibles

ODM will use the Part D Eligible Date in addition to Part A and Part B eligibility to determine drug coverage. Prescription drug coverage for dually eligible consumers is limited to those drugs that are excluded from coverage by Medicare Part D under the Social Security Act Sections 1927(d)(2) and 1935(d)(2). The following categories of Medicare-excluded drugs are covered for the dually-eligible population:

- Cough Suppressants
- Vitamin and mineral products, except prenatal vitamins and fluoride preparations
- Select over-the-counter drugs

To determine if a drug is excluded from Medicare Part D and covered by the state Medicaid pharmacy program, the online drug search tool is available at: http://pharmacy.medicaid.ohio.gov.

3.6 Consumer Payment Information [OAC 5160-9-09]

Medicaid consumers may be subject to a co-payment for medication if they are eligible adults age 21 years and over for Medicaid benefits. The co-payments that may be charged are as follows:

Description	Copay Amount
Medications that require a prior authorization	$3.00
Select trade name medication	$2.00
Multi-source brands with a non-preferred generic or preferred generic	$0.00

Co-payment Exemptions

Medications administered to a consumer in a hospital, emergency department, office, clinic, or other facility, are not subject to co-payments. Additionally, certain patient groups and situations are exempt from being charged a co-payment. These include:

- Persons under 21 years of age
- Pregnant women during the pregnancy and post-partum period (begins the last day of pregnancy and extends through the end of the month in which the sixty day period following termination of pregnancy ends)
- Persons receiving hospice care or identified as breast and cervical cancer patients
- Living arrangement is in a nursing home or immediate care facility for individuals with intellectual disabilities
- The prescription is for family planning (contraceptives)

Contact the **GHS Technical Call Center at 1-877-518-1545** for appropriate override if the consumer indicates that one of the above categories applies but the system has applied a co-payment. Living arrangement, hospice, and pregnancy may be indicated as part of the online claim to override co-payments when appropriate with the following overrides:

- Pregnancy Indicator = 2 (Pregnant) in NCPDP field #335-2C
- Hospice patient with Patient Residence = 11 in NCPDP field #384-4X
- LTCF living arrangement with Patient Residence = 3 (nursing facility) or 9 (intermediate care facility) in NCPDP field #384-4X

NOTE: Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid co-payment imposed by the co-payment program from a prior transaction as an outstanding debt and may refuse service to a Medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a Medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

Compounds

Compounds are assigned the highest copay applicable to each covered ingredient. If no ingredients have a copayment, then there is no copay. If any one or more has a copay, then copay charged is the highest single copay.

3.7 Prior Authorization [OAC 5160-9-03]

Prior authorizations (PAs) are administered in compliance with section 1927 of the Social Security Act, including a **response by fax within twenty-four hours of receipt of a request for prior authorization**, and provisions for the dispensing of a seventy-two-hour supply of a covered

outpatient prescription drug in an emergency situation.

Technical Call Center Prior Authorizations

For assistance with claims processing, eligibility, and third party liability, the pharmacist may call the **GHS Technical Call Center** at **1-877-518-1545**. Some common NCPDP rejection codes are noted below.

NCPDP	Message
41	Submit Bill to Other Processor
52	Non-matched Cardholder ID
56	Non-matched Prescriber ID
65	Patient is Not Covered
75	Living Arrangement/Nursing Home Criteria Not Met
79	Refill Too Soon
81	Claim Too Old
M2	Recipient Locked In

Clinical Call Center

Medications or treatment parameters (e.g., dose, duration, age) that require prior authorization must be initiated by the ***prescribing provider or member of the prescribing provider's staff***. Requests may be submitted by telephone or by fax. Some common NCPDP rejection messages are noted below.

A pharmacist may request prior authorization for an alternative dosage form of a drug to be administered through a tube for patients who are tube fed, if no comparable covered drug can be administered through a tube. **A pharmacist may also submit a seventy-two-hour supply of a covered outpatient prescription drug in an emergency situation if the prescribing provider or prescribing provider's staff is not available to request prior authorization for a drug denied with NCPDP code 75, as outlined below.**

NCPDP	Message
75	Prior Authorization Required
76	Plan Limitations Exceeded.
76	Quantity Exceeds Max
76	Days Supply Exceeds Max
76	Age Requirement Not Met
76	Max Quantity Allowed is Exceeded

- Upon a call from the prescriber, GHS will work with the prescriber to determine the outcome of the prior authorization request. Often, a change will be made to the drug. The requested drug may be authorized or denied. When a request for prior authorization is denied, the consumer will be informed in writing of the denial and the right to a state hearing.
- Prior authorization may also be requested by using the Request For Prior Authorization form. (See *Appendix A* for the PA request forms.)
- GHS clinical staff associates are available from 8AM – 8PM (ET) Monday through Friday.
- GHS will respond to all prior authorization requests within 24 hours of initiation of the request by the prescriber.

72-hour Emergency Supply

Pharmacy providers can utilize a 72-hour emergency fill when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. This emergency 72-hour fill provision is Federal law (Title 19, Section 1927(D)(5)(b)) and is applicable only to non-preferred medications that are included by the State's Medicaid pharmacy program.

In order to process a claim for an emergency 3-day supply, the pharmacy must submit a Prior Authorization Type Code (NCPDP field #461-EU) = 2 and Prior Authorization Number Submitted (NCPDP field #462-EV) = 72. Certain requirements apply for the pharmacy override:

- The PA will not override other edits on the claim (e.g. exceeding the daily dose).
- **Controlled substances, partial claims and consumers assigned to a lock-in program are excluded from this override process.**
- Overrides are limited to one unique drug entity per consumer, per month

The GHS Help Desk may be contacted when an override is necessary for an emergency situation and the pharmacy override process described above is unable to process the claim.

Medicare Part D Drugs

Drugs in therapeutic classes that are covered or may be covered under Medicare part D are not available for prior authorization for a consumer who is eligible for Medicare. Prior authorization may be requested for drugs in drug classes or portions of drug classes that may be covered for a dual eligible and are subject to any stated limits.

3.8 Coordination of Benefits (COB) *[OAC 5160-9-06; 5160-1-08]*

Starting in June 2016, **ODM will be switching to COB3 methodology** for the processing of claims submitted with primary Cost Avoidable (CA) coverage on the date of service. Prescription pricing will utilize Other Payer Amount Paid (NCPDP field #431-DV) <u>and</u> Other Payer Patient Responsibility Amount (NCPDP field #352-NQ) to determine the ODM payment for the claim. The details are fully described in this section.

Overview

Medicaid is the payer of last resort. Claims can only be submitted to Medicaid as primary payer when there is no other payer on file for the participant on the date of service. The only exception to this situation is when the consumer is covered by the Bureau for Children with Medical Handicaps (BCMH) and Medicaid is billed as the primary payer. BCMH will continue to be processed under BIN/PCN: 610084/ DRBCPROD.

Other coverage will be identified by the presence of other carrier information on the consumer's ODM eligibility file and/or information communicated by the provider on the claim. A rejection will occur if the pharmacy provider bills Medicaid as the primary payer when the consumer has other coverage as follows:

> *NCPDP Reject code*: 41 - Submit Bill to Other Processor or Primary Payer
> *Secondary message*: Carrier Name – consumer's TPL policy number – Carrier phone
>   number (if available)

NOTE: The TPL rejection can be overridden through prior authorization. There is no online override for pharmacies. Even if no other insurance is on the ODM eligibility file, GHS will process

the claim as a TPL claim if the pharmacy provider submits TPL data. Also, GHS will process as TPL claim if other insurance is indicated on the ODM eligibility file regardless of what TPL codes are submitted by the pharmacy provider.

If the provider determines that the consumer no longer has other coverage as identified by the ODM eligibility file, the ODM Cost Avoidance Unit may be contacted via email or fax. A form is available online to submit changes. The contact information is:

Fax: 614-728-0757
Email: tpl@medicaid.ohio.gov
Form: http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM06614fillx.pdf

The pharmacy may also request the recipient contact their eligibility caseworker to update TPL information.

COB Claims Submission

When submitting COB claims, the following information is required (*see payer sheet for additional requirements*):
- Other Payer ID and Qualifier (NCPDP field #34Ø-7C and 339-6C)
- Other Payer Amount Paid (OPAP) and Qualifier (NCPDP field #431-DV and 342-HC): Required on claims where the Other Coverage Code (OCC)= "2". Other Payer Amount Paid is the dollar amount of the payment received from the primary payer(s); this amount must be greater than $0.
  - When OCC= "4", the Other Payer Amount Paid cannot be greater than $0.
- Other Payer-Patient Responsibility Amount (OPPRA) and Qualifier (NCPDP field #351-NP and 352-NQ): Required on claims where OCC= "2" or "4" and amount must be greater than or equal to $0.
- Other Payer Date (NCPDP field #443-E8): Required on all COB claims. The Other Payer Date is the payment or denial date of the claim submitted to the other payer.
- Other Payer Reject Code (NCPDP field #472-6E): The Other Payer Reject Code is required when the OCC= 3.

Other Coverage Code (OCC)

The Other Coverage Code (NCPDP field #3Ø8-C8) is sent in the claim segment and is required on all COB claims. The following Other Coverage Codes (OCC) codes **are** allowed for COB claims billed to Medicaid:

Code	Description
2	**Other coverage exists- payment collected** Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received.
3	**Other coverage billed- claim not covered** Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered.
4	**Other coverage exists- payment not collected** Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received.

TPL Processing Summary and Chart

- When TPL is on file and OCC submitted is "0", the claim will reject with NCPDP error: 41 Submit Bill to Other Processor or Primary Payer.
- If a claim would reject, regardless of the TPL on file, when OCC is "2", "3", or "4", the pharmacy provider will be sent a message to contact the help desk.
- If OCC= 0, 1, 3, or 4 and a positive other payer amount paid amount is sent, the claim will reject as only an OCC = 2 can have a positive dollar value.
- If OCC= 4 and other payer amount paid amount is negative, it will be treated as a $0.00 and processed.
- If OCC= 0, 1 or 3 and other payer amount paid amount is negative, it will reject.
- If OCC= 2 and the dollar amount is less than $2.00, it will reject as NCPDP Reject code: DV – M/I Other Payer Amount Paid – Amount under minimum allowed.
- For OCC = 3, if the rejection code is '70' (drug not covered), the claim will be paid if Medicaid covers the drug. Otherwise, it will reject as NCPDP Reject code: 6E – M/I Other Payer Reject Code - Contact Help Desk.
- For OCC=2, the following edit types will be bypassed by Medicaid: NCPDP Reject code: 75- Prior Authorization Required and NCPDP Reject code 76 -Exceeds Max Days Supply, Quantity Limits, Age Criteria, and Gender Criteria.

OCC	Description	TPL on ODM File	TPL Not on ODM File
0	No insurance	Reject claim: NCPDP code 41 Help Desk can override with PA Any COB segment submitted: reject	Process claim Any COB segment submitted: reject
1	Pharmacy/Patient indicates no other coverage	Process claim Any COB segment submitted: reject	Process claim Any COB segment submitted: reject
2	TPL insurance billed, payment collected **NOTE:** OCC=2 claim, regardless of TPL on file or not on file, will process the same	OPAP < $2.00: Reject claim Help Desk can override with PA OPPRA < $0.00: Reject claim OPAP ≥ $2.00: Process claim OPPRA ≥ $0.00: Process claim	OPAP < $2.00: Reject claim Help Desk can override with PA OPPRA < $0.00: Reject claim OPAP ≥ $2.00: Process claim OPPRA ≥ $0.00: Process claim
3	TPL insurance billed, drug/service not covered	Require reject codes to be submitted; if missing, Reject 6E – M/I Other Payer Reject Codes Help Desk can override with PA OPAP > $0.00: Reject claim Reject Codes provided with OCC=3 Pay Claim with Reject Code = 70 Reject all other Reject Codes	Require reject codes to be submitted; if missing, Reject 6E – M/I Other Payer Reject Codes Help Desk can override with PA OPAP > $0.00: Reject claim Reject Codes provided with OCC=3 Pay Claim with Reject Code = 70 Reject all other Reject Codes
4	TPL insurance billed, payment not received **NOTE:** OCC=4 claim, regardless of TPL on file or not on file, will process the same	OPAP > $0.00: Reject claim OPPRA ≤ $0.00: Reject claim OPAP < $0.00: Process claim as 0 OPAP = $0.00: Process claim OPPRA > $0.00: Process claim	OPAP > $0.00: Reject claim OPPRA <= 0 Reject claim OPAP < $0.00: Process claim as 0 OPAP = $0.00: Process claim OPPRA > $0.00: Process claim

OPAP = Other Payer Amount Paid
OPPRA = Other Payer Patient Responsibility Amount

3.9 Long Term Care (LTC) Claims

Co-payments [OAC 5160-9-09]

ODM identifies consumers who reside in a long-term care facility (LTCF), including nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID). Prescriptions for medication given to these eligible consumers are excluded from co-payment at the time of dispensing.

Contact the **GHS Technical Call Center at 1-877-518-1545** for appropriate override if the consumer indicates that one of the above categories applies but the system has applied a co-payment. Living arrangement may be indicated as part of the online claim to override co-payments when appropriate with the following overrides:

- LTCF living arrangement with Patient Residence = 3 (nursing facility) or 9 (intermediate care facility) in NCPDP field #384-4X

Dispensing Fees [OAC 5160-9-05]

Please refer to **Section 3.3** for information on dispensing fees.

Over-the-counter (OTC) Medications [OAC 5160-9-03]

Selected over-the-counter drugs are payable to the pharmacy when dispensed to consumers residing in a nursing facility. OTC medications are the responsibility of the facility and reimbursed through the facility per diem fee. Please note that this applies only to residents of nursing facilities, and not to residents of ICF-IIDs. The following drug classes that contain OTC drugs are **NOT** separately reimbursable:
- Analgesics, including urinary analgesics;
- Compounding vehicles and bulk chemicals;
- Cough and cold preparations and antihistamines (except preparations containing cetirizine, fexofenadine, or loratadine);
- Ear preparations;
- Gastrointestinal agents (except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide);
- Hemorrhoidal preparations;
- Nasal preparations;
- Ophthalmic agents (except antihistamines);
- Saliva substitutes;
- Sedatives;
- Topical agents (except antifungal and acne preparations); or
- Vitamins and minerals (except prenatal vitamins and fluoride).

Claims for the OTC drugs listed above will be denied for patients whose Medicaid eligibility records show they reside in a nursing facility. If the pharmacy has knowledge that the patient does not reside in a long-term care facility, the pharmacy should call GHS at 1-877-518-1545 to request an override. The patient or patient's representative should be advised to have their Medicaid eligibility caseworker change the living arrangement in the eligibility record.

Tamper-resistant Prescriptions [OAC 5160-9-06]

The prescription is considered tamper resistant if the patient does not have opportunity to handle the written order. Orders for medications administered in a LTCF qualify if the order is written in the patient's medical record and given by medical staff directly to the pharmacy.

Vaccines [OAC 5160-9-03]

Vaccines, inoculations, and immunizations, other than seasonal and pandemic influenza vaccines, are covered as a pharmacy benefit only for residents of LTCFs. Otherwise, these services will be reimbursed as physician services. Seasonal influenza vaccines will be reimbursed at a rate of $0.50 per vaccine administered for a LTCF resident.

NOTE: Some injectable drugs are covered for consumers with a LTCF living arrangement or may be authorized for those receiving home health services.

3.10 Managed Care Plan (MCP) Consumers [OAC 5160-26]

Managed Care Plans are responsible for pharmacy benefits for their enrolled members. If the incoming pharmacy claim is for a consumer indicated as having MCP coverage on the date of service, the POS system will reject the claim with NCPDP Reject code: AF- Patient Enrolled Under Managed Care – Submit to $MCONAME$ - $MCOBIN$ - $MCOPCN$ - $MCOGROUP$. There is no override for MCP eligibility. This must be fixed through the state eligibility system.

For information on the Ohio Medicaid MCPs, please visit:
http://medicaid.ohio.gov/FOROHIOANS/Programs/ManagedCareforOhioans.aspx

3.11 Program of All-inclusive Care for the Elderly (PACE) [OAC 5160-36]

PACE is a managed care plan that provides participants with all of their needed health care, medical care and supplementary services in acute, sub-acute, institutional or community settings. If the consumer is identified as being a PACE program participant on the date of service the pharmacy claim is submitted to GHS then, the pharmacy provider will receive the NCPDP Reject code: AF - Patient Enrolled In Managed Care - Bill PACE site.

3.12 Lock-In Consumers (Coordinated Services Program [CSP])

GHS will be reviewing claims to identify patients that meet the clinical criteria for a pharmacy lock-in program. Criteria are approved under the guidance of the Ohio Medicaid DUR Board [OAC 5160-9-04]. Providers should call the GHS Technical Call Center (1-877-518-1545) for override consideration. Overrides will only be granted in the following situations:
- The dispensing provider has identified that the lock-in provider cannot dispense the medication (e.g., pharmacy closed or drug out of stock), *and* has determined the situation to be an emergency.

3.13 Medicare-Covered Drugs [OAC 5160-9-03; 5160-9-06]

GHS will verify Medicare Part A and B eligibility as well as the Part D eligible Date. Drugs in therapeutic classes that are covered or may be covered under Medicare Part D are not available for prior authorization for a consumer who is eligible for Medicare. If a claim comes to the state as primary payer for a Part B or Part D drug and the recipient is eligible for Part D or has Part A or Part B on the claim Date of Service then it will reject with NCPDP Reject code: 41 - PART D SERVICE - BILL MEDICARE.

The GHS Technical call Center will NOT override a rejection if the consumer is identified as a Medicare beneficiary. The pharmacy provider should contact the consumer's Medicare Prescription Drug Plan for assistance. If the consumer indicates that he or she does not have Medicare, the consumer should be advised to call his/her county eligibility caseworker.

3.14 Qualified Medicare Beneficiary (QMB)

Consumers with a QMB card are eligible only for payment of cost sharing associated with Medicare Part B-covered drugs not payable through the GHS system (*refer to Section 3.5*). The GHS Technical Call Center will NOT override a rejection if the consumer is identified as a having Medicare Part B on the ODM eligibility file. The pharmacy provider should contact the client's Medicare Prescription Drug Plan for assistance.

3.15 Compounds [OAC 5160-9-03; 5160-9-05]

Compounded drugs must be submitted using each national drug code (NDC) that is a part of the compound. Specific drug products and bulk ingredients utilized in compounds that are not covered will require prior authorization. If a prior authorization is not approved or if a component drug is not eligible for authorization (e.g. manufacturers not participating in the federal Medicaid rebate program), the pharmacy provider may elect to receive payment only for those items in the compound that are directly reimbursed by ODM. This can be processed by:

- Submitting the claim with the Submission Clarification Code (NCPDP field #42Ø-DK) of '08'.

Certain POS edits are different on compounded drugs. The below list is a summary of these differences.

Edit Type	Description
Age	**Age limits will be applied to compounds.** **[This is a change from the prior vendor.]**
Gender	**Gender limits will be applied to compounds.** **[This is a change from the prior vendor.]**
Duplicate therapy	If the single ingredient is a duplicate of another claim, it will not reject as a duplicate claim.
Refill too soon	Refill too soon edits will be bypassed except if sent more than once in the same compound.

Dispensing Fees

Please refer to **Section 3.3** for information on dispensing fees.

Compound Claims Submission

The following NCPDP fields are required to submit a claim for a compound via POS:
- Compound Code (NCPDP field #4Ø6-D6) is '2'
- **Product/Service ID (NCPDP field #4Ø7-D7) must be '0' [This is a change from the current vendor.]**
- Product/Service ID Qualifier (NCPDP field #436-E1) is '00'
- Compound Dosage Form field (NCPDP field #45Ø-EF) is to contain a value between "01"-"18"
- Compound Dispensing Unit field (NCPDP field #451-EG) is to contain a value of 1,2 or 3

- Compound Ingredient Component Count field (NCPDP field #447-EC) is to contain a value between "2"-"25"
- Compound Product ID Qualifier field (NCPDP field #488-RE) is to contain a value of "01","02", or "03"
- Compound Product ID field (NCPDP field #489-TE) is to contain the eleven digit NDC for the ingredient
- Compound Ingredient Quantity field (NCPDP field #448-ED) is to be populated with numeric value greater than zero for each ingredient
- Compound Ingredient Drug Cost field (NCPDP field #449-EE) is to be populated for each individual ingredient
- Compound Ingredient Basis Of Cost Determination (NCPDP field #49Ø-UE) is to contain a value between "01"-"14" for each ingredient

3.16 Influenza Vaccine Administration

Pharmacies may bill for administration of seasonal influenza vaccine through May 31 of each influenza season, and pandemic influenza vaccine when indicated. Payment for influenza vaccine administration will be made to pharmacies only for Medicaid consumers who do not reside in a long-term care facility (LTCF) and who are not eligible for Medicare. Vaccines are also not covered in the pharmacy setting for patients 18 years of age and younger (vaccine must be obtained from Vaccines for Children program).

Reimbursement for any pandemic influenza vaccine will be limited to an administration fee of no more than $10.00. The pandemic influenza vaccine is supplied by the Ohio Department of Health at no cost to the provider, so no reimbursement will be made for the vaccine itself. Reimbursement for the seasonal influenza vaccine will include product cost and an administration fee of no more than $10.00. No dispensing fee will be paid when the administration fee is billed. The influenza vaccine may be dispensed to LTCF residents for administration by staff and are eligible for a dispensing fee of $0.50.

Dispensing Fees

The summary provided below lists the current dispensing fees for vaccinations covered through the ODM pharmacy program.

Category	Dispense Fee
Influenza vaccine in LTCF	$0.50 per claim
Other vaccines in the LTCF (e.g. pneumococcal)	$1.80 per claim
Influenza vaccine administered at the pharmacy	$10.00 administration fee

Claim Submission for Administration at the Pharmacy

Medicaid will pay up to a $10.00 administration fee for the influenza when administered at the pharmacy. In order to receive payment for this fee, the provider will need to submit the administration fee in the Incentive Amount Submitted field (NCPDP field #438-E3) along with a Professional Service Code (NCPDP field #44Ø-E5) = **MA**.

Medicare Eligible

If a consumer is in Medicare, has Part A, Part B or are Part D eligible, they will not be eligible for vaccines. Any claim submitted on a Medicare consumer will reject with the NCPDP Reject code: 41 – Submit Bill to Other Processor or Primary Payer – Submit to Medicare.

LTCF

ODM pays a $0.50 dispensing fee for the influenza vaccine administered to residents of a LTCF. Additional vaccines are covered for this patient population and receive a regular dispensing fee.

3.17 Newborns Without an Assigned Medicaid ID

While newborns should be provided a Medicaid ID number, there may be cases where a newborn has not yet been assigned a Medicaid ID. Newborns are covered for prescriptions during the first 365 days after birth under the mother's Medicaid billing ID. The pharmacy provider will need to submit the claim with the mother's Medicaid ID and the baby's date of birth. The claim will be paid as long as the mother's Medicaid ID is used and the date of birth is within 365 days from the date of service. When a Medicaid ID has been issued to the newborn, the pharmacy provider should update their system and utilize the appropriate assigned Medicaid ID.

3.18 Partial Fills

The POS system will accept multiple partial fill transactions per prescription except for vaccines and other exceptions noted in this section. This transaction may be necessary when the full quantity prescribed is not currently in stock. If co-payment is required, the consumer will be charged the copay on the first partial prescription. The dispensing fee will only be paid on the completed prescription (LTCF exception). When a partial fill prescription is dispensed, but the participant does not receive the remainder of the prescription, the pharmacy must void the partial fill prescription and bill the prescription as a completed prescription to receive the dispensing fee.

Initial Partial Fill

The initial partial fill is sent with a 'P' in the Dispensing Status field (NCPDP field #343-HD). The quantity and days supply intended to be filled must be supplied on the claim (NCPDP field #344-HF and 345-HG) as well as the actual quantity and days supply dispensed (NCPDP field #442-EF and 4Ø5-DF). The dispensing fee is $0, but the co-pay is charged.

NOTE: Drug reimbursement is only for the quantity being dispensed in the partial claim. Multiple partial fills may be processed if they are for the same drug/strength/formulation, on different dates of service, and the accumulation of the dispensed quantity and days supply for all of the partial fills does not exceed the intended quantity and days supply. The same TPL edits apply for a partial fill as on a regular claim.

Completion Fill

When filling the remainder of the prescription, the Dispensing Status (NCPDP field #343-HD) must be sent with a 'C'. Similar fields are required as with the initial partial field. The provider dispensing fee is paid on the completion fill (LTCF exception). Partial and their completed counterpart claims are not allowed on the same date of service. If the pharmacy receives stock on the same day as the partial was dispensed, the pharmacy must reverse the partial and resubmit the claim with the total quantity and days supply.

3.19 Prescriber Validation

A prescriber must be enrolled to participate in the Medicaid program both on the date the prescription was written and the date dispensed for the pharmacy to be reimbursed for a prescription. All submitted claims must have the Prescriber ID Qualifier (NCPDP field #466-EZ) = '01', Prescriber ID (NCPDP field #411-DB), and the Prescriber last name (NCPDP field #427-DR). Any of these data fields missing will result in standard NCPDP rejection messages to the pharmacy provider.

If the prescriber NPI is in the ODM provider file, a last name match algorithm is applied using the first three to four characters of the prescribers last name or 'doing business as' name. **This is a new validation process.** Any mismatch will cause a rejection of NCPDP Reject code: DR - M/I Prescriber Last Name – Last Name mismatch with name on file. NPIs not found within the ODM provider file will result in a message back to the pharmacy as NCPDP Reject code: 25 - M/I Prescriber ID – 1339 Prescriber must register with Ohio Dept. of Medicaid. Other rejection messages pertaining to a non-active status and dates of service can occur.

Help Desk Assistance

The Help Desk will have a manual override to assist pharmacy providers. This override will be allowed when it has been determined that the prescriber is valid and he/she is not excluded from prescribing medications for the Ohio Medicaid program.

This override will not be used as a substitute for the prescriber to not register with the Ohio Department of Medicaid as required by the Affordable Care Act. Prescribers may enroll online at: http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx

Psychiatry Exemption

Physicians who have registered their psychiatry specialty with ODM are exempt from prior authorization for specific medications utilized to treat mental illness. This only applies to non-preferred medication coverage and will not override other POS edits like maximum days supply.

3.20 Miscellaneous

Additional information to assist in claims processing are noted below. Additional items not addressed elsewhere will be added, as necessary, to assist the pharmacy providers.

- The Prescription Origin Code (NCPDP field #419-DJ) is required. If this is not sent on the claim, it will reject with NCPDP Reject code: 33 - M/I Prescription Origin Code.

- A subsequent fill number on a prescription must be for the same drug/strength/formulation. If the pharmacy changes the drug without issuing a new prescription, it will reject with NCPDP Reject code: M4 - PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT.

- Package limits will be applied to various package sizes and formulations. This edit prevents incorrect billing of quantities that are not divisible by the package size in whole number increments for the product being dispensed. This edit applies to specific package types and dosage forms. If the Quantity Dispensed divided by the Package Size has a remainder (e.g. is not a whole number) the claim will message the pharmacy with NCPDP Reject code: 55 - Non-Matched Product Package Size. Compounds are exempt from this edit.

- **Vancomycin 5-gram and 10-gram vials for injection were previously billed by the milligram. Providers will need to start submitting the claims by the standard unit of measure: by each (per vial).**

Section 4: Prospective Drug Utilization Review [OAC 5160-9-04]

Pharmacy providers must perform Prospective Drug Utilization Review (ProDUR) for Medicaid consumers in accordance with Chapter 4729-5 of the Administrative Code. ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening at the time of claim adjudication. The ProDUR system assists the pharmacist in these functions by addressing situations in which potential drug problems may exist to ensure that their patients receive appropriate medications.

Because the ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. GHS recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

The ODM DUR Board approves drug utilization review criteria. Claims may be denied that exceed the established limitations set by this committee. Denials may be overridden by the GHS Help Desk in cases where medical necessity has been determined.

4.1 Therapeutic Edits

Therapeutic Duplication

When two or more medications from the same therapeutic drug class have the potential to increase the risk of adverse effects are targeted in therapeutic duplication. Currently, the ODM pharmacy program only allows one drug from each of the following drug classes dispensed in any three-week period:

- Antihistamines
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Proton Pump Inhibitors (PPIs)
- Sedative/Hypnotics
- Selective Serotonin Reuptake Inhibitors (SSRIs)

Pharmacy overrides using standard NCPDP intervention and outcome codes will be permitted for these therapeutic duplication edits and should be used only when the pharmacist believes it is clinically appropriate.

Drug-Drug Interaction

The ODM DUR Board has approved a select list of drug-drug interactions that are classified as having major significance in causing severe harm to patients. When different prescribers are listed on the prescriptions for this select list of severe drug interactions, a rejection will occur requiring the pharmacist to review and submit the appropriate NCPDP DUR codes to override the rejection.

NOTE: Anticoagulants and SMZ/TMP will require a pharmacist review regardless if the prescribers are the same or different on the prescriptions.

Other DUR Edits

Age, gender, dose and pregnancy edits for therapeutically appropriate and safe medication use, will require prior authorization by calling the GHS Clinical Call Center and cannot be overridden by the pharmacist.

4.2 ProDUR Override Codes

When a prescription rejects due to a ProDUR edit, the pharmacist has the ability to place in override codes after reviewing the claim. The below chart lists the three NCPDP fields required to allow an override and their common values.

NCPDP Field# & Name	Field Values
439-E4 **Reason for Service Code (Conflict Code)**	TD= Therapeutic Duplication ER = Drug Overuse Alert DD= Drug-Drug Interactions DC= Inferred Drug Disease Precaution PG= Drug Pregnancy Alert PA= Drug Age Precaution LD= Low Dose Alert HD= High Dose Alert NOTE: This code must match the rejection being overridden or the provider will receive a DUR reject error.
44Ø-E5 **Professional Service Code (Intervention Code)**	AS= Patient Assessment CC= Coordination of Care M0= Prescriber consulted MA= Medication Administration MP= Patient will be monitored MR= Medication Review P0= Patient consulted PH= Patient Medication History PM= Patient Monitoring R0= Pharmacist consulted other source SW= Literature Search/Review TH= Therapeutic Product Interchange
441-E6 **Result of Service Code (Outcome Code)**	1A= Filled as is, false positive 1B= Filled Prescription as is 1C= Filled with Different Dose 1D= Filled with Different Directions 1E= Filled with Different Drug 1F= Filled with Different Quantity 1G= Filled with Prescriber Approval 1K= Filled with Different Dosage Form 2A= Prescription Not Filled 2B= Not Filled, Directions Clarified 3A= Recommendation Accepted 3B= Recommendation Not Accepted 3C= Discontinued Drug 3D= Regimen Changed 3E= Therapy Changed 3F= Therapy Changed – cost increased acknowledged 3G= Drug Therapy Unchanged

Section 5: Edits

5.1 On-Line Claims Processing Messages

Following an on-line claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "**Paid**" message will be returned with the ODM allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message.

For rejected claims, the NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. For further assistance contact GHS at:

Technical Call Center
1-877-518-1545

For specific field requirements, please refer to the Ohio Medicaid NCPDP payer sheet available online at:

The Ohio Medicaid Drug Program: http://pharmacy.medicaid.ohio.gov

Goold Health Systems: http://www.ghsinc.com/payer-sheets

5.2 Host System Problems

Occasionally providers may receive a message that indicates their network is having technical problems communicating with GHS. For assistance, please contact the phone number provided above.

NCPDP	Message	Explanation
90	Host Hung Up	Host disconnected before session completed.
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
93	Planned Unavailable	Transmission occurred during scheduled downtime. GHS will provide system availability 7 days per week during regular business hours.
99	Host Processing Error	Do not retransmit claims.

Section 6: Provider Reimbursement [OAC 5160-9-05]

6.1 Provider Payment

Pharmacy providers are paid a dispensing fee and a drug ingredient cost on dispensed medications with some exceptions (*refer to section 3.3*). For medications that are subject to a co-payment, the amount reimbursed by ODM will be decreased by the amount equal to the co-payment that is to be billed to the consumer. Reimbursement for the drug ingredient cost shall be the lesser of the submitted charge or the calculated allowable in accordance with OAC 5160-9-05: Maximum allowable cost (MAC) or Estimated acquisition cost (EAC).

The EAC, assigned to all non-MAC drugs, is the Wholesale acquisition cost (WAC) plus 7% or the Average wholesale price (AWP) minus 14.4% if WAC is not available.

6.2 MAC Pricing

The Maximum allowable cost (MAC) has been determined by the federal Department of Health and Human Services for selected drugs. ODM shall not reimburse for these products, in the aggregate, at a rate higher than the federal upper limit (FUL) prices. ODM has established a MAC for additional selected drugs where either bio-equivalency of the drugs has been established or bio-inequivalency of the drugs has not been established. Reimbursement for state MAC drugs is based on the sixty-fifth percentile of the EAC of all readily available generically equivalent drugs.

Pharmacy providers may request a review of a MAC price if they are unable to obtain the medication at a reasonable cost. To submit a MAC dispute, please contact the Ohio Medicaid MAC Help Desk at:

Hours of Operation: Monday through Friday 8:30AM - 5:00PM
Phone: (844) 559-0607
Fax: (844) 592-7008
Email: OHSMAC@ghsinc.com
Web site: http://pharmacy.medicaid.ohio.gov/mac-information (MAC Request Form and MAC lists are available)

6.3 Provider Reimbursement Schedule

Contact the ODM Provider Network Management (1-800-686-1516) or log on to the MITS web portal (https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx) for questions regarding payment and Remittance Advices.

APPENDIX A: Prior Authorization Forms

Prior authorization forms that may be filled-in are available at: http://pharmacy.medicaid.ohio.gov

Standard Form

OHIO DEPARTMENT OF MEDICAID

Request for Rx Prior Authorization

Not to be used for: Synagis, Buprenorphine Products or Hepatitis C Medication PA Requests

Request Date: ____/____/_____

Patient Medicaid ID#:_____ _____	**Prescriber's Full Name:**_____ _____
Patient DOB:____/____/____	**Provider NPI #:**_____
Patient's Full Name:_____ _____	**PrescriberAddress:**_____ _____
Age:_____ **Height:**_____ **Wt:**_____ **Sex:**____	**Prescriber Ph#:**_____ **Prescriber Fax#:**_____

If Known:
Pharmacy Name: _____ **Pharmacy Ph#:** _____

Drug Requested:_____ **Strength:**_____ **Route:**_____ ◯ New
Frequency: _____ **Duration of Therapy:** _____ **Quantity:**_____ ◯ Renewal

Diagnosis and/or ICD-10 code (MUST BE INCLUDED TO AVOID DELAYS):_____

Pertinent past or present therapies (including OTCs and non-pharmacological):

Drug and Dose / Route / Frequency / Start Date / Stop Date / Outcome

Additional significant information for requesting a non-preferred drug(i.e. allergy, contraindications, drug-drug interactions, lab results etc.):_____

_____

_____

_____

Physician's Signature: _____ **Date:** ____/____/_____
(or agent of prescriber)

Fax To: OHIO Department of Medicaid
Fax: **(800) 396 - 4111**   PA Helpdesk: **(877) 518 - 1546**
ODM 03523 (5/2016)   Hours: Monday – Friday 8:00 am – 8:00 pm EST

Hepatitis C Form

OHIO DEPARTMENT OF MEDICAID
Request for Rx Prior Authorization: HCV Direct Acting Antiviral Medication

Request Date: ____/____/____

Patient Medicaid ID#:_____	**Prescriber's Full Name:**_____
Patient's Full Name:_____	**Provider NPI #:**_____
_____	**PrescriberAddress:**_____
Patient DOB:____/____/____	_____
	Prescriber Ph#:_____
	Prescriber Fax#:_____

If Known
Pharmacy Name: _____   **Pharmacy Ph#:** _____

Regimen Requested:_____   ◯ New
Frequency: _____   **Duration of Therapy:** _____   **Quantity:**_____   ◯ Renewal
Diagnosis (ICD-10): _____   **Baseline HCV RNA**_____   **Date of Baseline:**___/___/___
HCV Genotype and Subtype:_____
For PA Renewal: HCV RNA: _____   performed at what treatment week? _____
Note: Refills will NOT be granted unless there is a ≥ 2 log reduction in HCV RNA or unless the HCV RNA is <25 IU/ml)

Patient Readiness Evaluation

1. Age is greater than or equal to 18 years?   ◯YES ◯NO

2. For Females:
    a. Has the patient had a negative pregnancy test within the last 30 days?   ◯YES ◯NO
    b. Is the patient lactating?   ◯YES ◯NO

3. Within the last 6 months has the patient been free from alcohol use,   ◯YES ◯NO
    controlled drug use and illicit drug use?

4. Is the patient a recovering substance abuser/alcoholic?   ◯YES ◯NO
    a. If yes was indicated for question 4, is the patient in a   ◯YES ◯NO
        prescribed medication assisted therapy program?
    b. If yes was indicated for question 4 AND the patient is   ◯YES ◯NO
        receiving counseling, will the patient continue to receive
        counseling and maintain sobriety during HCV treatment?

PLEASE CONTINUE ONTO THE NEXT PAGE.
ALL PAGES MUST BE COMPLETED AND RETURNED.

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Fax: **(800) 396 - 4111**   PA Helpdesk: **(877) 518 - 1546**
Hours: Monday – Friday 8:00 am – 8:00 pm EST

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Revised: (5/2016)

OHIO DEPARTMENT OF MEDICAID
Request for Rx Prior Authorization: HCV Direct Acting Antiviral Medication

Patient Readiness Evaluation-Continued

5. Has the patient's psychiatric status been stable for 6 months and documented in the patients medical records?
   Note: If no, the patient must be evaluated by a Mental Health Professional   ◯ YES ◯ NO

6. Has the patient been vaccinated against Hepatitis A and Hepatitis B?   ◯ YES ◯ NO

7. Does the patient have severe renal impairment (eGFR < 30 mL/min/1.73m^2 or CrCl < 30mL/min)?   ◯ YES ◯ NO

8. Does the patient have end stage renal disease requiring hemodialysis?   ◯ YES ◯ NO

9. Is the prescriber monitoring the patient's drug profile for potentially clinically significant drug interactions?   ◯ YES ◯ NO

10. Is the Hepatitis C Readiness Form signed and attached?   ◯ YES ◯ NO
    (See last page for Hepatitis C Readiness Form)

Clinical Assessment of Disease

1. Was the hepatitis C virus (HCV) antibody test reactive?   ◯ YES ◯ NO

2. What is the patient's fibrosis score (list Ishak or Metavir score)?   _____   _____
                                                                             Ishak   Metavir

3. Is cirrhosis present?   ◯ YES ◯ NO
    a. If yes, is the cirrhosis compensated or decompensated?   ◯ YES ◯ NO
    b. If decompensated, has the patient had a consultation with a   ◯ YES ◯ NO
       physician in a liver transplant center?

4. What is the patient's Child Pugh Score?   _____

PLEASE CONTINUE ONTO THE NEXT PAGE.
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OHIO DEPARTMENT OF MEDICAID
Request for Rx Prior Authorization: HCV Direct Acting Antiviral Medication

Clinical Assessment of Disease-Continued

5. Dose the patient have a limited life expectancy (< 12 months) due to non-liver-related co-morbid conditions?   ◯ YES ◯ NO

6. Please list any HCV related extra hepatic manifestations (e.g. lymphoma, symptomatic cryoglobulinemia, membranoproliferative glomerulonephritis, etc): _____
_____
_____

7. Please list any relevant co-infections (e.g. HIV, Hepatitis B, etc):_____
_____

8. Please document any previously tried Hepatitis C treatments, including dates treated and responses/outcomes:
_____
_____

Additional Considerations for Coverage

1. Is the prescriber a specialist?   ◯ YES ◯ NO
   If yes, please indicate specialty: _____

   Note: The prescriber must be a hepatologist, gastroenterologist, or infectious disease specialist for therapy to be covered.

   Initial approval will be for 8 weeks.

   HCV RNA testing is required every 4 weeks during therapy. Treatment beyond the initial 8 weeks of therapy requires confirmation of lowered viral load. Refills will NOT be granted unless there is ≥ 2 log reduction in the HCV RNA or unless the HCV RNA is < 25 IU/mL.

   HIV/HCV-coinfected persons should be treated and re-treated the same as persons without HIV infection, after recognizing and managing interactions with antiretroviral medications.

   Only regimens listed as recommended or alternative in the current AASLD guidance (http://hcvguidelines.org) will be approved. Regimens listed as not recommended will not be approved.

   No lost or stolen medication will be replaced.

Prescriber's Signature: _____   Date: _____/_____/_____
(Or agent of Prescriber)

**PLEASE CONTINUE ONTO THE NEXT PAGE FOR HEPATITIS C PATIENT READINESS FORM
ALL PAGES MUST BE COMPLETED AND RETURNED.**

Fax To: Ohio Department of Medicaid
Fax: **(800) 396 - 4111**   PA Helpdesk: **(877) 518 - 1546**
Hours: Monday – Friday 8:00 am – 8:00 pm EST

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OHIO DEPARTMENT OF MEDICAID
Request for Rx Prior Authorization: HCV Direct Acting Antiviral Medication
Hepatitis C Patient Readiness Form:

_____ (print name) agrees to the
following:

1. I have not abused alcohol, injectable drugs, or other controlled substances for at least 6 months prior to starting Hepatitis C treatment, and I will not use these substances while being treated for Hepatitis C. If I am involved in a support group or counseling for addiction, I will continue therapy to encourage successful abstinence.

2. I have been reasonably adherent with all my current medications for all conditions and I will take my Hepatitis C treatment daily as prescribed.

3. I have a history of showing up for my scheduled appointments and labs, and will continue to show up for all appointments and lab tests while taking Hepatitis C treatment.

4. If I have mental health conditions, I have been and will continue to adhere to my prescribed mental health medications and/or psychotherapy.

Patient's Signature:_____ Date:____/_____/_____

Fax To: Ohio Department of Medicaid
Fax: **(800) 396 - 4111**   PA Helpdesk: **(877) 518 - 1546**
Hours: Monday – Friday 8:00 am – 8:00 pm EST

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Synagis Form

OHIO DEPARTMENT OF MEDICAID

Prior Authorization Form Synagis ® (palivizumab)   Request Date: ____/____/____

(Criteria Based on 2014 American Academy of Pediatrics Red Book Guidelines)

Supporting Documentation is REQUIRED for Synagis Request

Patient Medicaid ID#:_____	**Prescriber's Full Name:**_____
Childs's Name:_____	
☐ M ☐ F	**Provider NPI #:**_____
Patient DOB:___/___/___ **Age as of Nov 1st :** _____	
Gestational Age: Weeks_____ **Days** _____	**Prescriber Ph#:**_____
Birth Weight (kg): _____	**Prescriber Fax#:**_____
Current Weight (kg): _____	

If Known
Pharmacy Name: _____ **Pharmacy Ph#:** _____

DIAGNOSIS AND PATIENT HISTORY (CHECK ALL THAT APPLY):

☐ Prematurity (gestational age 28 weeks, 6 days or less)

☐ Chronic lung disease of prematurity during 1st year of life ($\leq$ 12 months of age) ICD-10 code required: _____
   <32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth.

☐ Chronic lung disease of prematurity during 2nd year of life (< 24 months of age) ICD-10 code required: _____
   <32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth.
   Requirement for continued medical support (e.g. chronic corticosteroid, bronchodilator, or diuretic therapy;
   supplemental oxygen) during 6-month period before start of second RSV season

   Treatment:
   Oxygen (dates/duration _____)   Steroids (dates/duration_____)
   Bronchodilators (dates/duration _____)   Diuretics (dates/duration_____)

☐ Hemodynamically significant CHD during 1st year of life (< 12 months of age) ICD-10 code required: _____

   • Diagnosis of hemodynamically significant acyanotic CHD?   ○ Yes   ○ No
   • Diagnosis of hemodynamically significant cyanotic CHD?   ○ Yes   ○ No
       ○ Consultation with a pediatric cardiologist regarding palivizumab? ○ Yes   ○ No
   • Diagnosis of moderate-to-severe pulmonary HTN?   ○ Yes   ○ No
   • List of medications used to control CHF_____

☐ Severe neuromuscular disease ($\leq$ 12 months of age) ICD-10:_____	☐ Receiving chemotherapy (check if patient is receiving chemotherapy)
☐ Congenital abnormalities of airways ($\leq$ 12 months of age) ICD-10: _____	☐ Undergoing cardiac transplantation ($\leq$ 24 months of age) Date _____
☐ Immunosuppressive/autoimmune disease ($\leq$ 24 months of age) ICD-10 required: _____	☐ Other:_____

Rx info: Synagis (palivizumab) 50mg and/or 100mg vials	Directions: Inject 15mg/kg IM one time per month
# Doses: _____ Date of first injection: _____	Qty: _____ Refills: _____

Prescriber's Signature: _____   Date: _____
(or agent of Prescriber)

Fax To: OHIO Department of Medicaid

Fax: **(800) 396 - 4111**   PA Helpdesk: **(877) 518 - 1546**

Revised: (5/2016)   Hours: Monday – Friday 8:00 am – 8:00 pm EST

Suboxone/Zubsolv Form

OHIO DEPARTMENT OF MEDICAID
Prior Authorization Form Suboxone/Zubsolv
Please refer to OAC § 4731-11-12 for reference

Request Date: ____/____/____
Form must be completed and submitted by a physician with a Drug Addiction Treatment Act (DATA) 2000 waiver ID
**Please ensure supporting documentation is provided **

Patient Medicaid ID#:_____ **Name:**_____ **DOB:**___/___/___ ○M ○F	**Prescriber's Name:**_____ **NPI#:**_____ **X-DEA#:**_____ **Prescriber Ph#:**_____ **Fax#:**_____
If Known: **Pharmacy Name:** _____ **Pharmacy Ph#:** _____	

Regimen Requested:_____ **Frequency:** _____ **Duration of Therapy:** _____ **Quantity:**_____	○ New ○ Renewal

FOR NEW PRESCRIPTIONS (Suboxone/Zubsolv SL):

1. Has physician reviewed the OARRS report within 7 days prior to the prior authorization request? ○ YES ○ NO
2. Diagnosis (not approvable for pain):_____ ICD-10 Code:_____
3. Has patient been referred to counseling for addiction treatment? ○ YES ○ NO
4. For doses of Suboxone ≥ 16 mg per day or ≥ Zubsolv 11.4mg per day:
   - Was the dose established before 1/31/2015? ○ YES ○ NO
   - Please provide the prescriber's specialty: _____

RENEWAL CRITERIA (Suboxone/Zubsolv SL):

1. Please provide the current duration of treatment as of the date of this request:_____
2. Please indicate the frequency of physician meetings:_____
3. Has patient been actively participating in counseling AND has been compliant with all sessions? ○ YES ○ NO
   Date of last counseling:_____ (1st year of treatment: attend minimum 12-step program meetings 3 times/week)
4. Has the dose been reduced in the past 6 months? ○ YES ○ NO
5. Has there been an evaluation for a dose reduction? ○ YES ○ NO
   If NO, please provide explanation:_____
6. Has physician reviewed the OARRS report within 7 days prior to the PA request? ○ YES ○ NO
7. If patient has received controlled substances for ≥ 12 weeks since the last authorization, has the physician
   coordinated with all prescribers of controlled substances and determined treatment should continue? ○ YES ○ NO
   If YES, has an addiction specialist recommended to continue substance abuse treatment? ○ YES ○ NO
8. Toxicology lab testing requirements met (monthly for 1st 6 months, then every 3 months)? ○ YES ○ NO
9. For doses of Suboxone ≥ 16 mg per day or ≥ Zubsolv 11.4mg per day:
   - Was the dose established before 1/31/2015? ○ YES ○ NO
   - Please provide the prescriber's specialty: _____

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OHIO DEPARTMENT OF MEDICAID
Prior Authorization Form Suboxone/Zubsolv
Please refer to OAC § 4731-11-12 for reference

FOR ALL REQUEST INVOLVING A "NON-PREFERRED" MEDICATION
[Bunavail, Buprenorphine SL tablets, Buprenorphine/Naloxone SL tablets]

A. For Buprenorphine:

Is the patient pregnant?	○ YES ○ NO
Is the patient breastfeeding a methadone-dependent baby?	○ YES ○ NO
Does the patient have an allergy to naloxone?	○ YES ○ NO

B. Is there a reason patient cannot use a preferred agent? — ○ YES ○ NO

Does the patient have a contraindication to preferred agent?	○ YES ○ NO
Does the patient have an allergy to the preferred agents?	○ YES ○ NO
Has the patient experienced an adverse effect(s) to a preferred agent?	○ YES ○ NO
Has the patient relapsed due to non-adherence or use of a preferred agent?	○ YES ○ NO

Additional Information: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Form must be completed and submitted by a physician with a Drug Addiction Treatment Act (DATA) 2000 waiver ID
**Please ensure supporting documentation is provided **

Prescriber's Signature: _____   Date: _____/_____/_____
(Or agent of Prescriber)

Fax To: Ohio Department of Medicaid
Fax: (800) 396 - 4111   PA Helpdesk: (877) 518 - 1546
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